Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

ALLEN S KENT MD
800 12TH AVENUE SUITE 200
FORT WORTH TEXAS 76104

Respondent Name
TARRANT COUNTY

Carrier's Austin Representative Box
Box Number 43

MFDR Tracking Number
M4- 06-0085-01

MFDR Date Received
August 29, 2005

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "CPT 22899 is not global to 22612 and was precertified from Fair Isaac letter dated 4/14/05. The graft that is global to 22612 is 20937. 22899 is an unlisted code and has no MAR rating. WC does pay for this service."

Amount in Dispute: $1,500.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "A review of the TWCC-60 reveals the Provider seeks reimbursement in the amount of $1,500 for services provided incident to an arthrodesis and fusion performed on June 17, 2004. The primary services were coded 22612, 22630 and 22842. The service at issue in this dispute is included within the primary service and it merits no separate reimbursement."

Response Submitted by: Harris & Harris

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 17, 2005	22899	$1,500.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute filed on or after January 1, 2003.
2. 28 Texas Administrative Code §134.202 sets out the fee guideline for professional medical services provided on or after September 1, 2002.
3. 28 Texas Administrative Code §134.600, sets out the preauthorization guidelines.
4. Division rule at 28 TAC §134.1, effective May 16, 2002, requires that services not identified in a fee guideline shall be reimbursed at fair and reasonable rates.

5. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated August 16, 2005
   - After review of the submitted documentation it has been determined that the Complete Global Service Data for Orthopaedic Surgery states 22899-placement of a graft is global to the procedure 27612-arthrodesis, posterior or posterolateral technique and should not be billed separately-Therefore, we are unable to recommend any additional allowance at this time.
   - 50 – These are non-covered services because this is not deemed a 'medical necessity' by the payer.

Issues

1. Did the requestor obtain preauthorization for CPT code 22899 denied by the insurance carrier as not medically necessary?
2. Is CPT code 22899 bundled into another CPT code rendered on the same date of service?
3. Does CPT code 22899 have an assigned Medicare value?
4. Did the requestor submit documentation to support fair and reasonable reimbursement for CPT code 22899?
5. Is the requestor entitled to reimbursement?

Findings

1. Per 28 Texas Administrative Code §134.600, preauthorization was obtained by the requestor prior to rendering the disputed charge(s). Review of the preauthorization letter from Fair Isaac, dated April 14, 2004, approved the disputed charge. Therefore medical necessity is not an issue and the disputed charges will be reviewed per the applicable rules.
2. Per 28 Texas Administrative Code §134.202 "(b) For coding, billing, reporting, and reimbursement of professional medical services, Texas Workers' Compensation system participants shall apply the Medicare program reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies in effect on the date a service is provided with any additions or exceptions in this section." CCI edits were run to determine if edit conflicts exists for date of service June 17, 2005. Review of the CCI edits finds:
   - No CCI edit conflicts were identified for CPT code 22899.
   - MDR will review the charge according to the applicable fee guidelines.
3. Per 28 Texas Administrative Code §134.202 "(c) To determine the maximum allowable reimbursements (MARs) for professional services system participants shall apply the Medicare payment policies with the following minimal modifications: (1) for service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Surgery, Radiology, and Pathology the conversion factor to be used for determining reimbursement in the Texas workers' compensation system is the effective conversion factor adopted by CMS multiplied by 125%." Review of the documentation finds that:
   - Review of the Medicare fee schedule did not contain a fee schedule amount for CPT code 22899.
   - CPT code 22899 is therefore subject to the provisions of 28 Texas Administrative Code §134.1.

   Per 28 Texas Administrative Code §134.202 "(c) To determine the maximum allowable reimbursements (MARs) for professional services system participants shall apply the Medicare payment policies with the following minimal modifications: (6) for products and services for which CMS or the commission does not establish a relative value unit and/or a payment amount the carrier shall assign a relative value, which may be based on nationally recognized published relative value studies, published commission medical dispute decisions, and values assigned for services involving similar work and resource commitments."

   Division rule at 28 TAC §134.1 requires that "Reimbursement for services not identified in an established fee guideline shall be reimbursed at fair and reasonable rates as described in the Texas Workers' Compensation Act, §413.011 until such period that specific fee guidelines are established by the commission."

   Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.

   Former 28 Texas Administrative Code §133.307(g)(3)(D), effective January 1, 2003, 27 *Texas Register* 12282, applicable to disputes filed on or after January 1, 2003, requires the requestor to provide "documentation that

discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement." Review of the submitted documentation finds that:

- The requestor billed CPT code 22899 on June 17, 2005.
- The CPT code 22899 does not have an assigned value by Medicare.
- Division rule at 28 TAC §134.1, effective May 16, 2002 requires that services not identified in a fee guideline shall be reimbursed at fair and reasonable rates.
- The requestor did not provide documentation to demonstrate how it determined its usual and customary charges for CPT code 22899.
- Documentation of the comparison of charges to other carriers was not presented for review.
- Documentation of the amount of reimbursement received for these same or similar services was not presented for review.
- The requestor did not submit documentation to support that payment of the amount sought is a fair and reasonable rate of reimbursement for the services in this dispute.
- The requestor did not support that the requested alternative reimbursement methodology would satisfy the requirements of 28 Texas Administrative Code §134.1.

The request for reimbursement is not supported. Thorough review of the submitted documentation finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement. Payment cannot be recommended for CPT code 22899.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	March 19, 2013 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.